Temporary Suspension or Waiver Request from Family Share

Child's Name:	
Child's CBIS No:	Family Share Account No:
Parent/Guardian's Name(s):	
Parent/Guardian's Address:	
Parent/Guardian's Phone Nu	umber: ()
Month/Year *Minimum one complete calen OR	
Month/Year	temporary waiver from their Family Share, from through, due to the following reason(s): Month/Year
OR	Share fee for this time period (maximum three calendar months at a time). a reduction of their Family Share from \$ to \$ from through, due to the following reason(s): Month/Year
Service Coordinator's Signa Service Coordinator's Name	Share fee for this time period (maximum three calendar months at a time). ture: e & Provider ID:
Service Coordinator's Addre	ess:
Phone: ()	Fax: ()
	cial Case Manager, Department for Public Health, Adult and Child Health ram, 275 E. Main Street HS2W-C, Frankfort, KY 40621
For Office Use Only Date received:	Approved:Yes No Signature